Wabanaki Public Health

Patient Navigation Model

Blood Pressure & Cholesterol Pilot

5 Tribal Health Centers

- Micmac Service Unit
- Penobscot Nation Health Center
- Maliseet Health and Wellness Center
- Pleasant Point Health Center
- Passamaquoddy Health Center at Indian Township

Tribal Health Center Resources

- PCP
- RN
- Pharmacist (Pleasant Point, Penobscot, Indian Township)
- Community Health Resource (CHR)
- Registered Dietician(PPHC, PHC, PNHC, MHWC)
- Fitness Coordinator
- Clinic Manager and Staff

Facilitation of trainings

- Master Blood Pressure trainings - QI
  - Providers re: the importance of accurate measurement for prescribing
  - Clinical staff
  - CHR's
- Cholesterol Screening in Community
  - Clinical staff
  - CHR's

Priority Population

- Each clinic will identify 10 priority or at risk clients who will have in home blood pressure and cholesterol screenings.
- Criteria to be determined by Health Directors

  Examples :

  - diagnosed with Hypertension or be at risk for
  - diagnosis of Diabetes mellitus
  - history of smoking

Screening

- CHR's or Clinical staff will go out into the community to do in home screening for identified individuals.
- Education regarding numbers as well as tools and resources will be provided.
- Results shared with Clinic

Next Steps – engaging patient

- Structured follow up mechanism
  - RN provided results, identify need for visit
  - Referral to RD for education as needed
  - Referral to Fitness Coordinator as needed
  - Pharmacist
    - Follow up call to patient along with education PRN
    - Pharmacy will notify provider if missed refills

FOLLOW UP

The method of follow up will depend on individual outcomes

Follow up will include:

- Phone calls from CHR, RN, RD, Pharmacists
- Reminder cards
- Emails

Goals

- Use of evidence based guidelines
- Establish a structured follow up model to monitor patients progress and schedule visits as needed
- Engage patients in their care

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